SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

Filing at a Glance

Company: Illinois Mutual Life Insurance Company

Product Name: Group VSTD	SERFF Tr Num: FRCS-127658169	State: Arkansas
TOI: H11G Group Health - Disability Income	SERFF Status: Closed-Approved-Closed	State Tr Num: 49902
Sub-TOI: H11G.002 Short Term	Co Tr Num: 5606	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Exselsa Cartwright	Disposition Date: 10/24/2011
	Date Submitted: 09/28/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: ILMUTUAL/61	Status of Filing in Domicile: Pending
Project Number: 61	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Submitted on or about this same date.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 10/24/2011	
State Status Changed: 10/24/2011	Deemer Date:
Created By: Exselsa Cartwright	Submitted By: Exselsa Cartwright

Corresponding Filing Tracking Number:

Filing Description:

We have been retained by Illinois Mutual Life Insurance Company to file the enclosed forms for approval in your state.

Our fee of $250 has been sent by EFT on this same date. This fee is based on the company's domicile state.

The Company offers their assurance that the Guaranty Association notice required by Regulation 49 will be provided.

This filing contains a group non-occupational short term disability and accidental death and dismemberment policy, certificate, group application, evidence of insurability form, and enrollment form.

SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

These forms are new forms and do not replace any existing forms. These forms are intended to be issued to employer groups. They will be marketed through licensed agents.

There are no unique or innovative features in this product.

The policy and certificate text found in brackets should be considered as variable material. Statements of Variability for the policy and certificate rider are attached.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions or need additional information, please call toll-free 1-800-927-2730. Thank you for your assistance.

Company and Contact

Filing Contact Information

Exselsa Cartwright, Senior Compliance Specialist	exselsa.cartwright@firstconsulting.com
1020 Central	800-927-2730 [Phone] 2757 [Ext]
Suite 201	816-391-2755 [FAX]
Kansas City, MO 64105	

Filing Company Information

(This filing was made by a third party - FC01)

Illinois Mutual Life Insurance Company	CoCode: 64580	State of Domicile: Illinois
300 S.W. Adams Street	Group Code:	Company Type:
Peoria, IL 61634	Group Name:	State ID Number:
(800) 437-7355 ext. [Phone]	FEIN Number: 37-0344290	

Filing Fees

Fee Required?	Yes
Fee Amount:	$250.00
Retaliatory?	No
Fee Explanation:	The domicile fee is $50 per form X 5 forms = $250.
Per Company:	No

SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Illinois Mutual Life Insurance Company	$250.00	09/28/2011	52219140

SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/24/2011	10/24/2011
Approved-Closed	Rosalind Minor	10/04/2011	10/04/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Group Non-occupational Short Term Disability Insurance Policy	Lynn Cravin	10/20/2011	10/21/2011
Form	Non-occupational Short Term Disability Income Insurance Certificate	Lynn Cravin	10/20/2011	10/21/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to Re-Open	Note To Reviewer	Lynn Cravin	10/19/2011	10/19/2011

SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

Disposition

Disposition Date: 10/24/2011
Implementation Date:
Status: Approved-Closed
Comment:

You requested that the filing be re-opened in order to change language in the policy and certificate. The revised policy and certification is approved effective on this date. The remainder of the forms will maintain the original approval date of October 4, 2011.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Statement of Variables	Approved	Yes
Supporting Document	Authorization	Approved	Yes
Form *(revised)*	Group Non-occupational Short Term Disability Insurance Policy	Approved	Yes
Form	Group Non-occupational Short Term Disability Insurance Policy	Replaced	Yes
Form *(revised)*	Non-occupational Short Term Disability Income Insurance Certificate	Approved	Yes
Form	Non-occupational Short Term Disability Income Insurance Certificate	Replaced	Yes
Form	Application for Group Insurance	Approved	Yes
Form	Application – Evidence of Insurability	Approved	Yes
Form	Voluntary Short Term Disability Employee Enrollment Form	Approved	Yes

SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

Disposition

Disposition Date: 10/04/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Statement of Variables	Approved	Yes
Supporting Document	Authorization	Approved	Yes
Form *(revised)*	Group Non-occupational Short Term Disability Insurance Policy	Approved	Yes
Form	Group Non-occupational Short Term Disability Insurance Policy	Replaced	Yes
Form *(revised)*	Non-occupational Short Term Disability Income Insurance Certificate	Approved	Yes
Form	Non-occupational Short Term Disability Income Insurance Certificate	Replaced	Yes
Form	Application for Group Insurance	Approved	Yes
Form	Application – Evidence of Insurability	Approved	Yes
Form	Voluntary Short Term Disability Employee Enrollment Form	Approved	Yes

SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

Amendment Letter

Submitted Date: 10/21/2011

Comments:

Thank you for re-opening this filing.

Since the date this filing was approved, we have learned that the Exceptions and Limitations on page 8 of the Policy differed from those on page 5 of the Certificate. The Exceptions and Limitations in the Policy were correct.

We have also learned that the Pre-Existing Condition Limitation provision on page 8 of the Policy and page 5 of the Certificate contained incorrect information. The changes made are summarized as follows:

1. 'prior to' was changed to 'after' in the second paragraph.
2. 'with that period' was deleted in the second paragraph.
3. For the certificate: "Your Coverage Date" is being used instead of Effective Date, since the employee's coverage date is appropriate in the Certificate rather than the Policy Effective Date.
4. For the policy, for the same reasons, Effective Date is now "Employee's Coverage Date".

We have attached corrected copies of the Policy and Certificate forms.

If you need any further information or have any questions, please call toll-free 1-800-927-2730. Thank you for your assistance.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
Form VSTD11 (AR)	Policy/Contract/Fraternal Certificate	Group Non-occupational Short Term Disability Insurance Policy	Initial				52.300	VSTD11 (AR) (2) APPROVED MTM 10-19.pdf

SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

Form VSTD11 CER (AR)	Certificate	Non-occupational Short Term Disability Income Insurance Certificate	Initial			54.400	VSTD11 CER (AR) approved mtm 10-19.pdf

SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

Note To Reviewer

Created By:
Lynn Cravin on 10/19/2011 03:03 PM
Last Edited By:
Sean Cox
Submitted On:
10/19/2011 04:43 PM
Subject:
Request to Re-Open
Comments:
Since the date this filing was approved, we have learned that the Pre-Existing Condition Limitation provision on page 8 of the Policy and page 5 of the Certificate contained incorrect information.

We ask that you re-open this filing so that we may substitute the corrected Policy and Certificate forms.

If you need any further information or have any questions, please call toll-free 1-800-927-2730. Thank you.

SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

Form Schedule

Lead Form Number: Form VSTD11 (AR)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 10/24/2011	Form VSTD11 (AR)	Policy/Contract/Fraternal Certificate	Group Non-occupational Short Term Disability Insurance Policy	Initial		52.300	VSTD11 (AR) (2) APPROVED MTM 10-19.pdf
Approved 10/24/2011	Form VSTD11 CER (AR)	Certificate	Non-occupational Short Term Disability Income Insurance Certificate	Initial		54.400	VSTD11 CER (AR) approved mtm 10-19.pdf
Approved 10/24/2011	Form VSTD11 APP	Application/Enrollment Form	Application for Group Insurance	Initial		50.000	Form VSTD11 APP.pdf
Approved 10/24/2011	Form VSTD11 EI	Application/Enrollment Form	Application – Evidence of Insurability	Initial		52.600	Form VSTD11 EI.pdf
Approved 10/24/2011	Form VSTD11 ENR	Application/Enrollment Form	Voluntary Short Term Disability Employee Enrollment Form	Initial		62.000	Form VSTD11 ENR.pdf

ILLINOIS MUTUAL®

A Mutual Life Insurance Company

Policyholder	[ABC COMPANY]	Date of Issue	[October 1, 2012]
Policy No.	[0001]	Policy Anniversary	[October 1, 2013] and annually thereafter
State of Delivery	Arkansas		
Premium Due Date	[October 1, 2012 and monthly thereafter]		

THE COMPANY AGREES TO PAY the group insurance benefits for each insured Employee of the Policyholder according to the terms of this Policy.

This Policy is issued to the Policyholder in consideration of the application of the Policyholder and the payment of the required premiums. It will take effect on the Date of Issue. This Policy will terminate upon failure to pay any premium before the end of the grace period allowed for payment. It will also terminate after written notice by the Company or by the Policyholder.

Premiums are payable in the amounts determined as stated herein. The first premium is due on the Date of Issue. Renewal Premiums are due as stated above during the continuance of this Policy unless the Policyholder and Illinois Mutual Life Insurance Company agree on some other method of premium payment.

This Policy is delivered in and is governed by the laws of the State of Delivery noted above.

This Policy is signed by our President and Secretary in Peoria, Illinois on the Date of Issue.

Secretary

Chairman & CEO

FOR INFORMATION, OR TO MAKE A COMPLAINT, CALL 800-437-7355
If you need information about your insurance, or should any dispute arise about your premium or about a claim that you have filed, call Illinois Mutual Life Insurance Company at the toll-free number listed above or contact the Arkansas Insurance Department, 1200 West Third Street, Little Rock, AR 72201 or toll-free at 1-800-282-9134.

Group Non-occupational Short Term Disability Insurance
and
Accidental Death and Dismemberment Insurance
Renewable at the Option of the Company

Illinois Mutual Life Insurance Company
Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 800.437.7355

INDEX

BENEFIT SCHEDULE

Class A **Class Description** Full-time active employees working [30] or more hours per week, Ages [18-67]

Qualifying Period [30-90] Days

Plan	Elimination Period Accident	Elimination Period Sickness	Maximum Total Disability Benefit Period	Plan	Elimination Period Accident	Elimination Period Sickness	Maximum Total Disability Benefit Period
[A	0 Days	7 Days	13 Weeks	E	7 Days	7 Days	26 Weeks
B	7 Days	7 Days	13 Weeks	F	14 Days	14 Days	26 Weeks
C	14 Days	14 Days	13 Weeks	G	14 Days	14 Days	52 Weeks
D	0 Days	7 Days	26 Weeks	H	30 Days	30 Days	52 Weeks

Each Employee may select a Level of Benefit listed below. The Employee's selection is included in the Employee's Enrollment Form and in the Employee's Schedule of Benefits included in his Certificate of Coverage.

Benefit Level	Weekly* Benefit	Minimum Annual Salary	Benefit Level	Weekly* Benefit	Minimum Annual Salary
1	$150	$11,700	6	$400	$31,200
2	$200	$15,600	7	$450	$35,000
3	$250	$19,500	8	$500	$39,000
4	$300	$23,400	9	$550	$42,900
5	$350	$27,300	10	$600	$46,800]

*Weekly Benefit cannot exceed 66 2/3% of Employee's Basic Weekly Earnings

Maximum Accidental Death and Dismemberment Benefit [$10,000]

Waiver of Premium [Included]

PREMIUM SCHEDULE

Premium Rates per $100 of Benefit – Employee Pays 100% of Premium

Age	[Plan A Premium	Plan B Premium	Plan C Premium	Plan D Premium
Under 30	$8.14	$7.75	$6.89	$9.56
30-34	$8.38	$8.00	$7.02	$9.91
35-39	$8.38	$8.00	$7.02	$9.91
40-44	$8.38	$8.00	$7.02	$9.91
45-49	$8.85	$8.38	$7.41	$11.45
50-54	$10.62	$10.13	$8.84	$13.69
55-59	$12.39	$11.88	$10.40	$16.17
60-64	$14.51	$13.88	$12.22	$18.88
65-69	$19.12	$18.25	$15.99	$24.90

Age	Plan E Premium	Plan F Premium	Plan G Premium	Plan H Premium
Under 30	$9.25	$8.32	$10.37	$8.19
30-34	$9.75	$8.71	$10.81	$8.50
35-39	$9.75	$8.71	$10.81	$8.50
40-44	$9.75	$8.71	$10.81	$8.50
45-49	$11.13	$10.01	$12.39	$9.74
50-54	$13.25	$11.96	$14.84	$11.74
55-59	$15.63	$14.17	$17.58	$13.75
60-64	$18.38	$16.51	$20.60	$16.23
65-69	$24.25	$21.84	$27.09	$21.32]

DEFINITIONS

For all purposes of this Policy:

Actively at Work means the Employee is performing all of the duties of his job with the Employer at least [30] hours per week.

Basic Weekly Earnings means the Employee's rate of earnings from the Employer in effect immediately prior to the date the Employee's Total Disability begins. It does not include bonuses, overtime pay and other extra compensation other than commissions. Commissions will be averaged over the 12 month period prior to the date of the Employee's Total Disability begins.

Coverage Date means the date which the Employee's coverage under the Policy begins.

Effective Date means the date on which the Policy becomes effective.

Elimination Period means the number of continuous days an Employee must be Totally Disabled before benefits begin to accrue and become payable. No benefits are payable for the Elimination Period. The Elimination Period may be different for disabilities due to Sickness than it is for Injury.

Employee means a person directly employed in the regular business of, and compensated for service by, the Employer. A director of a corporate employer shall not be deemed an Employee solely because of such directorship.

Employer means the entity or person, including any affiliates or subsidiaries named in the application, and who has agreed to provide benefits to its employees as provided in this Policy.

He and Him mean an insured Employee, whether male or female.

Injury means accidental bodily injury independent of disease, sickness or bodily infirmity that the Employee sustains while his coverage is in force and which does not arise out of any employment for wage or profit.

Physician means a doctor or practitioner, other than the Employee or a member of the Employee's immediate family, who is duly licensed by the proper authority and who is practicing within the scope of the Physician's license.

Policy means the group policy issued to the Employer.

Policy Anniversary means 12 months after the Date of Issue of this Policy to the Policyholder and each subsequent 12 month period.

Policyholder means the entity or person named in this Policy.

Pregnancy includes childbirth, miscarriages, and complications of Pregnancy.

Qualifying Period means the number of continuous days as stated in the Schedule of Benefits you are at Actively at Work before your Coverage Date may begin if you apply for coverage under the Policy.

Regular Care of a Physician means treatment, consultations and diagnostic services provided by a Physician whose specialty is suitable for the condition causing your disability. Such care must be received in-person at a frequency that is appropriate for the Employee's Injury or Sickness according to accepted medical standards. We may waive this regular care requirement upon receipt of reasonable proof that such care is no longer appropriate for the Injury or Sickness causing the Employee's disability.

Sickness means an illness, disease, or physical condition of the Employee which first manifests itself while his coverage is in force and which does not arise out of any employment for wage or profit. Pregnancy is covered as any other sickness for the purpose of providing benefits under this Policy, subject to all Policy provisions.

DEFINITIONS (cont.)

Total Disability for any one period of disability, starting while the Employee's coverage is in force, means, as a result of Sickness or Injury, the Employee's inability to engage in any occupation for which he is qualified or for which he becomes qualified by education, training, or experience.

To be Totally Disabled, the Employee must be under the regular care of a physician. Only one total disability benefit will be payable at any one time even if the Employee is Totally Disabled because of multiple causes.

We, Us and Our mean Illinois Mutual Life Insurance Company or the Company.

PREMIUM PROVISIONS

Computation of Premiums: The premium rates shown in the Schedule shall be used in computing the amounts of premiums due Policyholder under the Policy. However, the Company may, on any of the following dates, establish a new rate upon which further premiums shall be computed:

1. any premium due date, provided the rate schedule that is then in effect has been in effect at least 12 months, and the Company notifies the Policyholder at least 31 days in advance of such premium due date; or
2. whenever the terms of this Policy are changed.

As of the Effective Date of this Policy, the Company will determine the premiums due for each enrolled Employee based on his age last birthday and the amount of insurance coverage selected.

Thereafter, on each Policy Anniversary:

1. a premium adjustment will be made for any Employee whose attained age places him in a higher premium bracket; and/or
2. a premium adjustment will be made for any Employee who requests a change in his benefit level because of a salary increase/decrease that has occurred for that employee. The Employee must furnish evidence of insurability if his benefit level is to be increased. Such changes must be approved by the Company.

Premium adjustments that involve a return of unearned premium, will be returned to the Employee upon receipt by the Company of evidence that such adjustment should be made.

Payment of Premiums: All premiums due under this Policy, and any adjustments, are to be paid on or before their due date. Premiums are to be paid at the Home Office of the Company. The payment of any premiums shall keep this insurance in force only through the date just before the next due date, unless otherwise stated herein.

Grace Period – Termination of Policy: A grace period of 31 days will be allowed for payment of any premium due after the first. No interest will be due for the grace period. During the grace period this Policy shall stay in force. However, this Policy shall not stay in force during the grace period if the Policyholder has, prior to the premium due date, given written notice to the Company that this coverage is to be terminated on the day immediately preceding such premium due date.

If the Policyholder fails to pay any premium within the grace period, coverage for its Employees shall automatically terminate on the last day of such grace period. The Policyholder shall, nevertheless, be liable to the Company for the payment of all premiums then due and unpaid. This shall include a pro rata premium for the grace period.

Written notice may be given by the Policyholder to the Company during the grace period that its coverage is to be terminated before the expiration of the grace period. If so, coverage shall be terminated as of the later of:

1. the date of receipt of such written notice by the Company, or
2. the date specified by the Policyholder for such termination.

PREMIUM PROVISIONS (cont.)

The Policyholder shall be liable to the Company for the payment of all premiums then due and unpaid. This shall include a pro rata premium for the period starting with the last premium due date and ending with such date of termination.

The Company may terminate this Policy on the first policy anniversary or on any premium due date thereafter. It may do so if it gives written notice to the Policyholder at least 31 days in advance.

ADMINISTRATION PROVISIONS

Record of Employees Insured
The Company shall maintain a record which shall show at all times the following:

1. the names of all Employees insured hereunder;
2. the date when each Employee became insured;
3. the amount for which he is insured;
4. the effective date of any increase or decrease in the amount of his insurance;
5. information necessary to determine the age of each Employee; and
6. such other information as may be required to administer the insurance hereunder.

The Policyholder shall furnish from time to time to the Company such information about Employees becoming insured and terminations of employees as the Company may require. The Company will be allowed to examine the records of the Policyholder relating to this Policy. This may be done at any reasonable time up to 2 years after the cancellation of this Policy, or until settlement of all claims, whichever is later.

Inadvertent error, failure or omission on the part of the Policyholder to report the name of any Employee who has qualified for the insurance hereunder in accordance with the prescribed conditions, or whose amount of insurance is to be changed in accordance with the provisions hereof, shall not deprive such Employee of insurance nor affect the amount thereof. Failure to report the termination of insurance on any Employee shall not be construed as involving or effecting the continuation of such insurance beyond the date of termination determined in accordance with the provisions hereof.

Employee's Certificate
The Company will issue a Certificate of Insurance for each insured Employee. The Certificate will be delivered to the Employee and shall state the insurance protection. It shall state such limitations or requirements in this Policy as may pertain to the insured Employee.

INSURANCE PROVISIONS

Employees Eligible for Insurance
Subject to the provisions of this Policy, each Employee is eligible for insurance from the Effective Date if he:

1. has completed a continuous employment period of [0-90] days;
2. is a full-time Employee working [30-40] hours per week or more; and
3. is between the ages of 18 through 65.

Each person who becomes a full-time Employee after the Effective Date is eligible for insurance on the first day after he completes a continuous employment period of [0-90] days.

Effective Dates of Insurance
Each Employee who makes a written request for insurance on a Company form shall, subject to the provisions of this Policy, become insured as follows:

1. If he makes the request on or before the date he becomes eligible, he shall become insured on the date he becomes eligible.
2. If he makes the request within 31 days after the first day he is both eligible and Actively at Work, he shall become insured on the date of the request.

3. If he makes the request more than 31 days after the first day on which he is both eligible and Actively at Work, he shall become insured on the date the Company agrees to his insurability.

If an Employee is not Actively at Work as a full-time employee on the date he would otherwise become insured, he will not become insured until the next day on which he is Actively at Work as a full-time employee.

Individual Termination of Insurance
The insurance on an Employee shall terminate upon the earliest of the following dates:

1. the date his employment is terminated with the Employer. An Employee's employment is deemed terminated if he is no longer Actively at Work except for periods during which he is eligible for Total Disability Weekly Benefit;
2. the date the Policy is terminated or amended to end coverage for class to which an Employee belongs;
3. the date of termination of the Policy; or
4. the date of the expiration of the last period for which he has made a contribution, in the event of his failure to make, when due, any contribution toward the payment of premium for insurance to which he has agreed in writing.

Termination of the Policy will not affect any claim that the Employee may have for a loss that begins prior to the termination of the Policy.

NON-OCCUPATIONAL DISABILITY INCOME BENEFITS

Total Disability Weekly Benefit
If injury or sickness causes the Employee's Total Disability, we shall pay him the Total Disability Weekly Benefit shown in the Schedule which he has elected. However, in no event shall this Benefit be more than 66 2/3% of the Employee's Basic Weekly Earnings. This Benefit shall be paid to him after the Elimination Period shown in the Schedule has been satisfied. This Benefit shall be paid to him for as long as he is Totally Disabled up to the Maximum Total Disability Benefit Period shown in the Schedule for any one period of total disability.

If termination of insurance coverage occurs during a period of total disability, benefits will continue to be paid until the earliest of:

1. the date his Total Disability ends; or
2. the Maximum Total Disability Benefit Period has been reached.

However, any Total Disability Weekly Benefit payable under the Policy will be reduced by the amount of any other income benefits which the Employee receives or is eligible to receive. Other income benefits are:

1. [retirement pension benefits to the extent paid for by the Employee under
   a. any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with the Employer; or
   b. any plan which the Employer sponsors, or makes or has made contributions] [and]
2. disability benefits under any plan of a federal, state, county or municipal retirement system, if such benefits include any credit for employment with the Employer; and
3. disability benefits under the United States Social Security Act, the Railroad Retirement Act or under any similar United States or Canadian plan or act; and
4. unemployment compensation under any state or federal law; and
5. disability benefits under any individual or group disability policy paid for by the Policyholder and purchased on or after the Effective Date of the Policy; and
6. amounts received under any salary continuation, paid time off or accumulated sick leave plan sponsored by the Policyholder. This includes donated or lump sum sick leave benefits or paid time off.]

NON-OCCUPATIONAL DISABILITY INCOME BENEFITS (cont.)

[The Total Disability Weekly Benefit will never be less than [$50].]

For any period of Total Disability for which a Benefit is payable that is less than a full week, the benefit will be prorated. Proration will be determined by dividing the amount of the Employee's Total Disability Weekly Benefit by 7 and multiplying this amount by the number of days he is Totally Disabled.

Recurrent Disability
A recurrence of the Employee's disability from the same or related causes will be considered a continuation of the prior period unless he has been engaged in any gainful occupation for more than 14 continuous days. The Employee must be reasonably fitted and have been performing all of the substantial and material duties of that occupation.

If the Employee's disability is treated as a recurrent Total Disability of the prior period, it will not be subject to a new Elimination Period or a new Maximum Total Disability Benefit Period.

PRE-EXISTING CONDITION LIMITATION

During the first 12 months after the Employee's Coverage Date, we will not pay benefits:

(a) for any condition diagnosed or treated by a physician within 12 months prior to the Employee's Coverage Date; or
(b) for any condition which caused symptoms within 12 months prior to the Employee's Coverage Date that would have caused an ordinarily prudent person to seek medical diagnosis, care or treatment.

In the event the Employee applies for an increased benefit level, we will not pay benefits on the increased portion of the benefit level during the first 12 months after the effective date of the Employee's increased benefit level for any condition diagnosed or treated by a physician or for any condition which caused symptoms within 12 months prior to the effective date of the Employee's increased benefit level that would have caused an ordinarily prudent person to seek medical diagnosis, care or treatment.

EXCEPTIONS AND LIMITATIONS

The Employee's coverage does not insure against or pay benefits for any disability which is caused by or is the result of:

(a) intentionally self-inflicted injuries or attempted suicide, while sane or insane; or
(b) his commission of a felony; or
(c) war, declared or undeclared; or
(d) Injury or Sickness arising out of or in the course of any employment for wage or profit.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

An Accidental Death and Dismemberment Benefit will be payable up to the Accidental Death and Dismemberment Benefit stated on the Schedule, provided such loss:

1. Results from Injury, independent of disease and Sickness; and
2. Is caused by an accident that occurs while this Benefit is in force; and
3. Occurs within 90 days of that accident.

A percentage of this Benefit will be paid to the Employee as follows:

Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and the Entire Sight of One Eye	100%
Loss of One Foot and the Entire Sight of One Eye	100%
Loss of One Hand or One Foot	50%
Loss of Entire Sight of One Eye	50%

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (cont.)

For this Benefit to be payable, Loss means:

1. with reference to hand or foot, complete loss of the use of the hand, or foot; and
2. with reference to eye, irrecoverable loss of the entire sight of the eye.

If the Employee suffers more than one of the above losses as a result of the same accident, the Benefit provided will be paid only for the greatest loss.

This Benefit will be paid to the Employee, if living; otherwise to the named Beneficiary. If no Beneficiary is named, the Benefit will be paid to the Estate of the Employee.

The Accidental Death and Dismemberment Benefit will provide no Benefit for any loss caused by or resulting from:

1. Declared or undeclared war or any act of war;
2. Service in the armed forces of any country or international authority;
3. Suicide or intentionally self-inflicted injury whether the Employee was sane or insane at the time of the suicide or injury.
4. Flying in an aircraft owned, operated, leased or chartered by the Policyholder;
5. Participation in, or in consequence of having participated in, the commission of any felony;
6. Sickness or disease, or infection, except infections which result from an accidental injury or infections which result from accidental, involuntary or an unintentional ingestion of a contaminated substance.
7. Intentionally taking a narcotic, drug, barbiturate, hallucinogenic drug or any combination of these when not part of a professional medical treatment plan.
8. Intoxication by the intentional use of alcohol. Intoxication means that which is defined and determined by the laws of the state where the loss or cause of the loss was incurred.

BENEFICIARY PROVISION

The beneficiary shall be as shown in the Employee's enrollment form for this coverage. The Employee may change a beneficiary at any time by sending a written request to us unless an irrevocable beneficiary has been named.

A change of beneficiary will not take effect until it is recorded by us. When the change is so recorded, it will take effect as of the date that the written request was signed, whether or not the Employee is living when the change is recorded. We will not be liable for any proceeds paid prior to such recording.

WAIVER OF PREMIUM PROVISION

The premium for insurance for the Employee will be waived in certain situations. He must become entitled to receive Total Disability Weekly Benefits under the Policy. His total disability must have existed for at least 90 days in a row. If these two conditions are met, we will waive each monthly premium due for his insurance after his first 90 days of Total Disability. When he is no longer Totally Disabled, premiums must be paid as they become due.

GENERAL PROVISIONS

1. Entire Contract: This Policy and the application of the Policyholder, a copy of which is attached hereto, constitute the entire contract between the parties.

All statements made by the insured Employee shall be deemed representations and not warranties and no statement made by an insured Employee shall avoid the insurance or be used in defense to a claim hereunder unless a copy of the instrument containing such statement is or has been furnished to such Employee.

2. Amendment and Alteration of the Contract: This Policy may be amended or changed at any time, subject to the laws of the jurisdiction in which it is delivered, without the consent of the Employees insured hereunder by written agreement between the Policyholder and the Company.

Only the President, a Vice President, the Secretary or an Assistant Secretary of the Company has power to change, modify or waive the provisions of this Policy, and then only in writing. The Company shall not be bound by any promise or representation heretofore or hereafter made by or to any agent or person other than as above.

3. Notice of Claim: Written notice of a claim must be given to us within 20 days after a loss starts or as soon as reasonably possible. Such notice may be given to Our Home Office or to any of our authorized agents. Such notice should include the Employee's name.

4. Claim Forms: Upon receipt of notice of claim, we will send the forms for filing proof of loss. If these forms are not furnished within 15 days, the Employee will have met the proof of loss requirements by giving Us a written statement of the nature and extent of the claim within the time stated below for Proofs of Loss.

5. Proofs of Loss: Written proof of loss for a periodic payment due for a continuing loss must be given to us within 90 days after the end of each period for which We are liable. For any other loss, written proof of loss must be given within 90 days after such loss.

If it was not reasonably possible for the Employee to give such proof within the time required, we shall not reduce the claim for such reason if the proof is filed as soon as reasonably possible. Such proof must be given no later than one year from the time specified above unless lack of legal capacity prevents it.

6. Time of Payment of Claim: After receiving written proof of loss, we will pay at the end of each 7 days all benefits for the Employee's continuing disability for which we are liable. Any balance unpaid at the end of the disability will be paid as soon as we receive written proof. Benefits for any other loss covered by the Policy will be paid as soon as we receive proper written proof.

7. Payment of Claim: Subject to due proof of loss, benefits will be paid each week during any period for which we are liable. Any balance unpaid at the termination of such period will be paid upon receipt of due proof.

All benefits will be paid to the Employee. However, in the following cases we may pay up to $1,000 to any relative by blood or connection by marriage of the Employee who is deemed by Us to be fairly entitled thereto:

(a) when the benefit is payable to his estate;
(b) when the benefit is payable to a minor;
(c) when the benefit is payable to anyone else that is not legally competent.

Any payment made by us in good faith under this provision shall fully discharge Us to the extent of such payment.

8. Physical Examination and Autopsy: We shall have the right at our expense to have the Employee examined as often as is reasonably necessary while a claim is pending. Benefits shall cease if the Employee does not submit to an examination when reasonably requested by us. At our own expense, we may have an autopsy made unless prohibited by law.

9. Legal Actions: No legal action may be taken to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No legal action may be taken after 3 years from the time written proof of loss is required to be given.

GENERAL PROVISIONS

10. Misstatement of Age: If the Employee's age has been misstated, we shall adjust the premium. If his amount of insurance would be affected by such misstatement of age, it shall be adjusted to that to which he would have been entitled at his correct age. The adjustment in premium shall be based on such adjusted amount of insurance.

11. No Assignment: The Employee's Certificate of Insurance cannot be assigned. The benefits cannot be assigned prior to a loss.

12. Incontestability: We may contest the validity of the Employee's insurance only if:

(a) we contest a statement made by him relating to his insurability within 2 years of the date his insurance initially became effective or within 2 years of the effective date of an increase in the benefit amount; and

(b) the statement is in writing and signed by him.

13. Reinstatement: If any renewal premium is not paid within the grace period, this Policy will lapse. Later acceptance of the premium by us or by our agent authorized to accept premiums, without requiring an application for reinstatement, will reinstate this Policy.

If we or our agent require an application, the Policyholder will be given a conditional receipt for the premium. If the application is later approved by us, this Policy will be reinstated as of the date of our approval. If not approved by us, this Policy will be reinstated on the 45th day after the date of the conditional receipt unless we have already given the Policyholder written notice of its disapproval.

After reinstatement, this Policy will cover only [(i)] a total disability that results from an injury sustained after the date of reinstatement or a sickness that begins more than 10 days after such date. [or (ii) a loss that results from an accident so long as the accident occurs after the date of reinstatement.]

In all other respects the Employee's rights and our rights will stay the same, subject to any provisions that are endorsed on or attached to this Policy at the time of reinstatement.

14. Conformity With State Statutes: Any provision of the Policy which, on its effective date, is in conflict with a law of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of said law.

Group Non-occupational Short Term Disability Insurance
and
Accidental Death and Dismemberment Insurance
Renewable at the Option of the Company

Illinois Mutual Life Insurance Company
Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 800.437.7355

FOR INFORMATION, OR TO MAKE A COMPLAINT, CALL 800-437-7355
If you need information about your insurance, or should any dispute arise about your premium or about a claim that you have filed, call Illinois Mutual Life Insurance Company at the toll-free number listed above or contact the Arkansas Insurance Department, 1200 West Third Street, Little Rock, AR 72201 or toll-free at 1-800-282-9134.

ILLINOIS MUTUAL®

A Mutual Life Insurance Company

GROUP INSURANCE PLAN

CERTIFICATE OF INSURANCE

Non-occupational Short Term Disability Income Insurance
and
Accidental Death and Dismemberment Insurance

This Certificate is issued to all employees of the Employers who become eligible for benefits, subject to the provisions of Policy, as described in this certificate.

Employee [John Doe] **Certificate No.** [0001]

Effective Date [October 1, 2012]

Employer [ABC Company]

BENEFIT SCHEDULE

Class A **Class Description** Full-time active employees working [30] or more hours per week, Ages [18-67]

Qualifying Period [30-90] days
Elimination Period
Accident [8] Days
Sickness [8] Days

Maximum Total Disability Benefit Period

Total Disability Weekly Benefit

*Weekly Benefit cannot exceed 66 2/3% of Your Basic Weekly Earnings

Maximum Accidental Death and Dismemberment Benefit [$10,000]

Waiver of Premium [Included]

This Certificate of Insurance is intended to present the Group Plan in non-technical language. As a Certificate of Insurance, it explains but it is not the contract of insurance which has been issued to and is in the possession of the Employer at its Home Office.

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DEFINITIONS

Actively at Work means you are performing all of the duties of your job with the Participating Employer at least [30] hours per week.

Basic Weekly Earnings means your rate of earnings from the Employer in effect immediately prior to the date your Total Disability begins. It does not include bonuses, overtime pay and other extra compensation other than commissions. Commissions will be averaged over the 12 month period prior to the date your Total Disability begins.

Coverage Date means the date which your coverage under the Policy begins.

Effective Date means the date on which the Policy becomes effective.

Elimination Period means the number of continuous days you must be Totally Disabled before benefits begin to accrue and become payable. No benefits are payable for the Elimination Period. The Elimination Period may be different for disabilities due to Sickness than it is for Injury.

Employee means a person directly employed in the regular business of, and compensated for service by, the Employer. A director of a corporate employer shall not be deemed an Employee solely because of such directorship.

Employer means the employer who has agreed to provide group insurance benefits to its employees.

Injury means accidental bodily injury independent of disease, sickness or bodily infirmity that you sustain while your coverage is in force and which does not arise out of any employment for wage or profit.

Physician means a doctor or practitioner, other than you or a member of your immediate family, who is duly licensed by the proper authority and who is practicing within the scope of his license.

Policy means the group policy issued to the Employer which provides the coverage described in this Certificate.

Pregnancy includes childbirth, miscarriages, and complications of Pregnancy.

Qualifying Period means the number of continuous days as stated in the Schedule of Benefits you are at Actively at Work before your Coverage Date may begin if you apply for coverage under the Policy.

Regular Care of a Physician means treatment, consultations and diagnostic services provided by a Physician whose specialty is suitable for the condition causing your disability. Such care must be received in-person at a frequency that is appropriate for your Injury or Sickness according to accepted medical standards. We may waive this regular care requirement upon receipt of reasonable proof that such care is no longer appropriate for the Injury or Sickness causing your disability.

Sickness means an illness, disease, or physical condition of you which first manifests itself while your coverage is in force and which does not arise out of any employment for wage or profit. Pregnancy is covered as any other sickness for the purpose of providing benefits under this Policy, subject to all Policy provisions.

Total Disability for any one period of disability, starting while your coverage is in force, means, as a result of Injury or Sickness, your inability to engage in any occupation for which you are or for which you become qualified by education, training, or experience. To be Totally Disabled, you must be under the Regular Care of a Physician. Only one Total Disability benefit will be payable at any one time even if you are Totally Disabled because of multiple causes.

We, Us and Our mean Illinois Mutual Life Insurance Company or the Company.

You and Your refers to the insured Employee named in the Schedule.

YOUR ELIGIBILITY FOR GROUP COVERAGE

You become eligible:

(a) on the Effective Date of the Policy, if you are within the eligible classes insured; or

(b) on the day immediately following completion of the required Qualifying Period, if you are within the eligible classes after the Effective Date of the Policy.

YOUR GROUP COVERAGE BEGINS

Your coverage begins:

(a) on the date you become eligible, if you have made application on or before said date.

(b) on the date you make application, if you have made application within 31 days after you became eligible.

(c) on the date we approve your evidence of insurability, if you make application more than 31 days after the date you first became eligible.

Your coverage does not begin unless you are Actively at Work. If you are not Actively at Work, your coverage begins on the first day you are Actively at Work.

YOUR COVERAGE TERMINATES

Your coverage terminates immediately upon the earliest of the following dates:

(a) the date your employment is terminated with the Employer. Your employment is deemed terminated if you are no longer Actively At Work except for periods during which you are eligible for Total Disability Weekly Benefit;

(b) the date the Employer terminates coverage under the Policy;

(c) when you fail to make a premium payment when due; or

(d) when you cease to be within a class eligible for insurance.

Termination of the Policy will not affect any claim you may have for a loss that begins prior to the termination of the Policy.

NON-OCCUPATIONAL DISABILITY INCOME BENEFITS

Total Disability Weekly Benefit

If Injury or Sickness causes your Total Disability, we shall pay you the Total Disability Weekly Benefit shown in the Schedule which you elected. However, in no event shall this Benefit be more than 66 2/3% of your Basic Weekly Earnings. This Benefit shall be paid to you after the Elimination Period shown in the Schedule has been satisfied. This Benefit shall be paid to you for as long as you are Totally Disabled up to the Maximum Total Disability Benefit Period shown in the Schedule for any one period of Total Disability.

If termination of insurance coverage occurs during a period of Total Disability, benefits will continue to be paid until the earliest of:

1. the date your Total Disability ends; or
2. the Maximum Total Disability Benefit Period has been reached.

However, any Total Disability Weekly Benefit payable to you under the Policy will be reduced by the amount of any other income benefits which you receive or are eligible to receive. Other income benefits are:

1. [retirement pension benefits to the extent paid for by the Employee under
   a. any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with the Employer; or
   b. any plan which the Employer sponsors, or makes or has made contributions][and.
2. disability benefits under any plan of a federal, state, county or municipal retirement system, if such benefits include any credit for employment with the Employer; and
3. disability benefits under the United States Social Security Act, the Railroad Retirement Act or under any similar United States or Canadian plan or act; and

NON-OCCUPATIONAL DISABILITY INCOME BENEFITS (cont.)

4. unemployment compensation under any state or federal law; and
5. disability benefits under any individual or group disability policy paid for by the Policyholder and purchased on or after the Effective Date of the Policy; and
6. amounts received under any salary continuation, paid time off or accumulated sick leave plan sponsored by the Policyholder. This includes donated or lump sum sick leave benefits or paid time off.]

[The Total Disability Weekly Benefit will never be less than [$50].]

For any period of Total Disability for which a Benefit is payable that is less than a full week, the benefit will be prorated. Proration will be determined by dividing the amount of your Total Disability Weekly Benefit by 7 and multiplying this amount by the number of days you are Totally Disabled.

Recurrent Disability
A recurrence of your Total Disability from the same or related causes will be considered a continuation of the prior period unless you have been engaged in any gainful occupation for more than 14 continuous days. You must be reasonably fitted and have been performing all of the substantial and material duties of that occupation.

If your Total Disability is treated as a recurrent Total Disability of the prior period, it will not be subject to a new Elimination Period or a new Maximum Total Disability Benefit Period.

PRE-EXISTING CONDITION LIMITATION

During the first 12 months after Your Coverage Date, we will not pay benefits:

(a) for any condition diagnosed or treated by a physician within 12 months prior to Your Coverage Date; or
(b) for any condition which caused symptoms within 12 months prior to Your Coverage Date that would have caused an ordinarily prudent person to seek medical diagnosis, care or treatment.

In the event you apply for an increased benefit level, we will not pay benefits on the increased portion of the benefit level during the first 12 months after the effective date of your increased benefit level for any condition diagnosed or treated by a physician or for any condition which caused symptoms within 12 months prior to the effective date of your increased benefit level that would have caused an ordinarily prudent person to seek medical diagnosis, care or treatment.

EXCEPTIONS AND LIMITATIONS

1. Your coverage does not insure against or pay benefits for any disability which is caused by or is the result of:
   (a) intentionally self-inflicted injuries or attempted suicide, while sane or insane; or
   (b) his commission of a felony; or
   (c) war or act of war, whether declared or undeclared; or
   (d) injury or sickness arising out of or in the course of any employment for wage or profit.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

An Accidental Death and Dismemberment Benefit will be payable up to the Accidental Death and Dismemberment Benefit stated on the Schedule, provided such loss:

1. results from Injury, independently of disease [or Sickness]; and
2. is caused by an accident that occurs while this Benefit is in force; and
3. occurs within 90 days of that accident.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (cont.)

A percentage of this Benefit will be paid to the Employee as follows:

Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and the Entire Sight of One Eye	100%
Loss of One Foot and the Entire Sight of One Eye	100%
Loss of One Hand or One Foot	50%
Loss of Entire Sight of One Eye	50%

For this Benefit to be payable, Loss means:

1. with reference to hand or foot, complete loss of the use of the hand, or foot; and
2. with reference to eye, irrecoverable loss of the entire sight of the eye.

If you suffer more than one of the above losses as a result of the same accident, the Benefit provided will be paid only for the greatest loss.

This Benefit will be paid to you, if living; otherwise to the named Beneficiary. If no Beneficiary is named, the Benefit will be paid to your estate.

The Accidental Death and Dismemberment Benefit will provide no Benefit for any loss caused by, or resulting from:

1. Declared or undeclared war or any act of war;
2. Service in the armed forces of any country or international authority;
3. Suicide or intentionally self-inflicted injury whether the Employee was sane or insane at the time of the suicide or injury.
4. Flying in an aircraft owned, operated, leased or chartered by the Employer;
5. Participation in, or in consequence of having participated in, the commission of any felony;
6. Sickness or disease, or infection, except infections which result from an accidental injury or infections which result from accidental, involuntary or an unintentional ingestion of a contaminated substance.
7. Intentionally taking a narcotic, drug, barbiturate, hallucinogenic drug or any combination of these when not part of a professional medical treatment plan.
8. Intoxication by the intentional use of alcohol. Intoxication means that which is defined and determined by the laws of the state where the loss or cause of the loss was incurred.

BENEFICIARY PROVISION

The beneficiary shall be as shown in your enrollment form for this coverage. You may change a beneficiary at any time by sending a written request to us unless an irrevocable beneficiary has been named.

A change of beneficiary will not take effect until it is recorded by us. When the change is so recorded, it will take effect as of the date that the written request was signed, whether or not you are living when the change is recorded. We will not be liable for any proceeds paid prior to such recording.

WAIVER OF PREMIUM PROVISION

The premium for insurance for you will be waived in certain situations. You must become entitled to receive Total Disability Weekly Benefits under the Policy. Your Total Disability must have existed for at least 90 days in a row. If these two conditions are met, we will waive each monthly premium due for your insurance after your first 90 days of Total Disability. When you are no longer Totally Disabled, premiums must be paid as they become due

GENERAL PROVISIONS

1. Notice of Claim: Written notice of a claim must be given to us within 20 days after a loss starts or as soon as reasonably possible. Such notice may be given to our Home Office or to any of our authorized agents. Such notice should include your name.

2. Claim Forms: Upon receipt of notice of claim, we will send the forms for filing proof of loss. If these forms are not furnished within 15 days, you will have met the proof of loss requirements by giving us a written statement of the nature and extent of the claim within the time stated below for Proofs of Loss.

3. Proofs of Loss: Written proof of loss for a periodic payment due for a continuing loss must be given to us within 90 days after the end of each period for which we are liable. For any other loss, written proof of loss must be given within 90 days after such loss.

If it was not reasonably possible for you to give such proof within the time required, we shall not reduce the claim for such reason if the proof is filed as soon as reasonably possible. Such proof must be given no later than one year from the time specified above unless lack of legal capacity prevents it.

4. Time of Payment of Claim: After receiving written proof of loss, we will pay at the end of each 7 days all benefits for your continuing disability for which we are liable. Any balance unpaid at the end of the disability will be paid as soon as we receive written proof. Benefits for any other loss covered by the Policy will be paid as soon as we receive proper written proof.

5. Payment of Claim: Subject to due proof of loss, benefits will be paid each week during any period for which we are liable. Any balance unpaid at the termination of such period will be paid upon receipt of due proof.

All benefits will be paid to you. However, in the following cases we may pay up to $1,000 to any relative by blood or connection by marriage of yours who is deemed by us to be fairly entitled thereto:

(a) when the benefit is payable to your estate;
(b) when the benefit is payable to a minor;
(c) when the benefit is payable to anyone else that is not legally competent.

Any payment made by us in good faith under this provision shall fully discharge us to the extent of such payment.

6. Physical Examination and Autopsy: We shall have the right at our expense to have you examined as often as is reasonably necessary while a claim is pending. Benefits shall cease if you do not submit to an examination when reasonably requested by us. At our own expense, we may have an autopsy made unless prohibited by law.

7. Legal Actions: No legal action may be taken to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No legal action may be taken after 3 years from the time written proof of loss is required to be given.

8. Misstatement of Age: If your age has been misstated, we shall adjust the premium. If your amount of insurance would be affected by such misstatement of age, it shall be adjusted to that to which you would have been entitled at your correct age. The adjustment in premium shall be based on such adjusted amount of insurance.

9. No Assignment: Your Certificate of Insurance cannot be assigned. The benefits cannot be assigned prior to a loss.

10. Incontestability: We may contest the validity of your insurance only if:

(a) we contest a statement made by you relating to your insurability within 2 years of the date your insurance initially became effective or within 2 years of the effective date of an increase in the benefit amount; and
(b) the statement is in writing and signed by you.

11. Reinstatement: If any renewal premium is not paid within the grace period, this Policy will lapse. Later acceptance of the premium by us or by our agent authorized to accept premiums, without requiring an application for reinstatement, will reinstate this Policy.

If we or our agent require an application, the Policyholder will be given a conditional receipt for the premium. If the application is later approved by us, this Policy will be reinstated as of the date of our approval. If not approved by

us, this Policy will be reinstated on the 45th day after the date of the conditional receipt unless we have already given the Policyholder written notice of its disapproval.

After reinstatement, this Policy will cover only

[(a)] a Total Disability that results from an Injury sustained after the date of reinstatement or a Sickness that begins more than 10 days after such date[; or

(b) a loss that results from an accident so long as the accident occurs after the date of reinstatement.]

In all other respects your rights and our rights will stay the same, subject to any provisions that are endorsed on or attached to this Policy at the time of reinstatement.

12. Conformity With State Statutes: Any provision of the Policy which, on its effective date, is in conflict with a law of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of said law.

Non-occupational Short Term Disability Income Insurance
and
Accidental Death and Dismemberment Insurance
Renewable at the Option of the Company

Illinois Mutual Life Insurance Company
Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 800.437.7355

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355

Application for Group Insurance

Application is made for a policy of group insurance to be issued in consideration of the payment of premium and the statements made herein.

1. Employer Information

a. Full Legal Name of Employer _____

b. Telephone Number (_____) _____ c. Employer's Federal Tax ID Number _____

d. Type of Business _____

e. Address _____
STREET CITY STATE ZIP CODE

f. Administrative Correspondence with the employer should be addressed to:

_____ _____
NAME TITLE

g. Nature of Business _____

h. Requested Effective Date (12:01 a.m.): _____, 20 _____. Subject to acceptance by the Company at its Home Office on the 1st Day of the month.

i. Premiums are to be paid monthly.

j. Are there subsidiary or affiliate businesses covered under this plan? ☐ Yes ☐ No

If Yes, please state name and nature of each subsidiary or affiliate _____

_____

k. Are separate billings required? ☐ Yes ☐ No If Yes, please provide billing instructions.

_____

l. Will the requested insurance replace existing insurance? ☐ Yes ☐ No If Yes, give coverage, name of existing carrier, and proposed termination date _____

_____

2. Employee Eligibility

a. The normal work week for full-time employees is _____ hours.
Eligibility: All regular full-time employees working a minimum of (30) hours per week.

b. Number of Eligible Employees _____ c. Number of Enrolled Employees _____

d. Are there any ineligible classes or divisions? ☐ Yes ☐ No If Yes, please describe: _____

_____

e. Are any eligible employees disabled at this time? ☐ Yes ☐ No If Yes, please describe: _____

_____

f. Is a Section 125 Plan in effect? ☐ Yes ☐ No g. Will this Plan be subject to the Section 125 Plan? ☐ Yes ☐ No

3. Voluntary Short Term Disability Benefit Level

(a.) Employer's Plan Selected_____

Plan	Elimination Period Accident	Elimination Period Sickness	Maximum Total Disability Benefit Period	Plan	Elimination Period Accident	Elimination Period Sickness	Maximum Total Disability Benefit Period
A	0 Days	7 Days	13 Weeks	E	7 Days	7 Days	26 Weeks
B	7 Days	7 Days	13 Weeks	F	14 Days	14 Days	26 Weeks
C	14 Days	14 Days	13 Weeks	G	14 Days	14 Days	52 Weeks
D	0 Days	7 Days	26 Weeks	H	30 Days	30 Days	52 Weeks

(b.) Qualifying Period (# of Continuous Days an Employee is Actively at Work before the Employee may apply for Coverage): _____ [30-90]

4. Employer's Signature
PLEASE READ CAREFULLY
I understand that the insurance benefits resulting from this application will be provided by Illinois Mutual Life Insurance Company under a group policy issued to the Employer.

Quotations were based on the proposal data submitted to Illinois Mutual Life Insurance Company. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.

If the initial deposit is at least equal to the first month's premium, and if the requested insurance is acceptable under Illinois Mutual's current rules and practices, insurance under the terms of the policy shall be effective on the effective date requested. In the interim, liability is limited to a return of the original deposit. Only Illinois Mutual's home office has the authority to guarantee the acceptability of the requested insurance.

Notice: Insurance applicants must acknowledge a fraud warning statement. Please refer to the specific fraud warning statement for your state (or the General Fraud Statement if your state is not listed) as indicated below. Your signature and date on this application indicates that you acknowledge the fraud warning applicable in your state of residence and, if applicable, the state in which this application is signed.

Dated at _____ this _____ , 20 _____
CITY/STATE DATE

_____ _____ _____
SIGNATURE OF EMPLOYER TITLE WITNESS

5. Agent's Report

a. Initial Deposit (Minimum first month's premium is required.): $_____

b. Are all the employees to be insured for Disability Income covered by Workers' Compensation? ☐ Yes ☐ No
If No, explain: _____

c. Have you explained to the employer that an employee not actively at work on the policy effective date will not be covered until such employee _____ returns to active work full-time? ☐ Yes ☐ No Remarks: _____
_____

d. Is there another group insurance plan(s) which duplicates any of the benefits applied for with this application that will remain in force or be placed concurrently with this plan(s)? ☐ Yes ☐ No If Yes, please describe the benefit amounts and purpose(s) of this plan(s): _____
_____
_____

e. Is Agent or Broker licensed in the State of this group for the types of insurance solicited? ☐ Yes ☐ No

f. To the best of the Agent's or Broker's knowledge, replacement ☐ is ☐ is not involved with this transaction

g. Print name of Agent/Broker _____

h. Signature of Agent/Broker _____ Date _____

GENERAL FRAUD STATEMENT: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Arkansas, Louisiana and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Underwritten by: Illinois Mutual Life Insurance Company
Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 309.674.8255

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355

Application – Evidence of Insurability

This form must be completed and submitted with the enrollment form after the expiration of the initial eligibility period.

1. Name of Applicant _____ Group No. _____
LAST FIRST MI

2. Address _____
STREET CITY STATE ZIP CODE

3. Occupation _____

4. Have you been actively at work for the last 90 days? ☐ Yes ☐ No If no, provide details:_____

_____

5. Health Questions

a. Height _____ ft._____ in. b. Weight _____ lbs. c. Amount of weight lost in past year _____ lbs.

d. In the last 5 years, have you had or been told by a medical practitioner that you had, or been treated for:
(1) Cancer, high blood pressure, diabetes, hepatitis, mental illness, arthritis or deformity? ☐ Yes ☐ No
(2) Disorder of the back, muscles, knees, heart, respiratory system or nervous system? ☐ Yes ☐ No

e. Has a medical practitioner diagnosed you as having or treated you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No

f. Have you ever been treated or counseled for drug or alcohol abuse or used heroin, cocaine, marijuana or other controlled substances, except as legally prescribed? ☐ Yes ☐ No

g. In the last 5 years, have you had any treatment, medical advice or surgery or have you been on any prescription medication not indicated above? ☐ Yes ☐ No

h. Provide details to Questions c - g which have been answered Yes. (Attach additional sheet if needed)

Question #	Illness, Injury or Other	Date	Details, Length of Disability and Degree of Recovery	Complete Name of Physician, Hospital Clinic and Current Address

I agree and understand that I will not be insured until this application has been approved by the Company and payment of the required premium has been received.

Authorization: I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, Veteran's Administration, MIB, Inc., Social Security Administration, my employer, consumer reporting agency, insurance or reinsuring company, or insurance support organization, who possesses medical or other information on me to furnish such information to Illinois Mutual Life Insurance Company, hereinafter called the Company, or its legal representative upon presenting this Authorization or a photocopy. The Company, its reinsurers, insurance support organizations and their authorized representatives may obtain medical and other information, in order to evaluate my application for insurance or my eligibility for benefits under an existing policy. This Authorization shall include information concerning drugs, alcoholism, AIDS or mental illness. I understand that the Company or its reinsurers may make a brief report concerning me to other insurance companies to whom I have applied or may apply for coverage.

I have read this Authorization and understand that I may receive a copy upon request. I understand and agree that this Authorization shall be valid for two years from the date shown below.

Notice: Insurance applicants must acknowledge a fraud warning statement. Please refer to the specific fraud warning statement for your state (or the General Fraud Statement if your state is not listed) as indicated below. Your signature and date on this application indicates that you acknowledge the fraud warning applicable in your state of residence and, if applicable, the state in which this application is signed.

Signed at _____ _____
CITY/STATE SIGNATURE OF PROPOSED INSURED

Date _____

GENERAL FRAUD STATEMENT: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Arkansas, Louisiana and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Underwritten by: Illinois Mutual Life Insurance Company
Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 309.674.8255

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355

Voluntary Short Term Disability
Employee Enrollment Form

Name of Employer _____

Name _____ Date of Birth _____
LAST FIRST MI

Address _____
STREET CITY STATE ZIP CODE

Social Security Number _____-_____-_____ Date Employed Full-Time _____

Coverage Effective Date _____ Occupation _____

Annual Earnings $_____ Hours worked per week _____ Sex: ☐ Male ☐ Female

Beneficiary _____ Relationship _____

BENEFIT LEVELS
Check the Benefit Level (1-10) that meets your needs from the chart below.

Benefit Level	Weekly Benefit	Your Annual Salary Must Be at Least
☐ 1	$150	$11,700
☐ 2	$200	$15,600
☐ 3	$250	$19,500
☐ 4	$300	$23,400
☐ 5	$350	$27,300
☐ 6	$400	$31,200
☐ 7	$450	$35,000
☐ 8	$500	$39,000
☐ 9	$550	$42,900
☐ 10	$600	$46,800

BENEFIT LEVEL SELECTED

Benefit Level may not be greater than
66 $^{2}/_{3}$% of your Basic Weekly Earnings

I elect the above Benefit Level for which I am eligible. I authorize my employer to deduct the necessary contribution from my wages to pay the cost of this insurance. I understand that if I select a Benefit Level less than that for which I am eligible, I can apply to increase the Benefit Level, subject to proof of my insurability, and approval of the Company.

Notice: Insurance applicants must acknowledge a fraud warning statement. Please refer to the specific fraud warning statement for your state (or the General Fraud Statement if your state is not listed) as indicated. Your signature and date on this application indicates that you acknowledge the fraud warning applicable in your state of residence and, if applicable, the state in which this application is signed.

Date_____ Your Signature _____

If you are refusing coverage, sign below and return this form to your employer.

I acknowledge that I have been offered Voluntary Short Term Disability Insurance by my employer. I hereby wish to waive my right to be insured under this plan. I am aware that I must furnish evidence of insurability satisfactory to Illinois Mutual Life Insurance Company, at my own expense, if I should apply at a later date. The Company shall have the right to decline coverage.

Date_____ Your Signature _____

GENERAL FRAUD STATEMENT: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

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Underwritten by: Illinois Mutual Life Insurance Company
Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 309.674.8255

SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	10/24/2011

Comments:

Attachments:

AR RDB.pdf

AR Complaint Notice.pdf

AR COC.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	10/24/2011

Comments:

See Form Schedule

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variables	Approved	10/24/2011

Comments:

Attachments:

VSTD11 CER SOV (AR).pdf

VSTD11 SOV (AR).pdf

		Item Status:	Status Date:
Satisfied - Item:	Authorization	Approved	10/24/2011

Comments:

Attachment:

AUTHO.pdf

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: Illinois Mutual Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
VSTD11	52.3
VSTD11 CER	54.4
VSTD11 APP	50.0
VSTD11 EI	52.6
VSTD11 ENR	62.0

Maureen T. Mullville, CLU, FLMI
Vice President of Compliance and General Counsel

September 15, 2011
Date

ILLINOIS MUTUAL®
Life Insurance Company

300 S.W. Adams Street Peoria, IL 61634
800.437.7355

ARKANSAS IMPORTANT NOTICE

The following information is provided as required by Arkansas Act 197 of 1987:

Illinois Mutual Life Insurance Company
Policy Service Department
300 S.W. Adams Street
Peoria, IL 61634
(800) 437-7355

Agent _____
Address _____
_____
Phone _____

If we at Illinois Mutual Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 W. Third Street
Little Rock, AR 72201-1904
(501) 371-2640
(800) 852-5494

Form 3101 (10/09)

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: Illinois Mutual Life Insurance Company

Form Title(s): Group Non-occupational Short Term Disability Insurance Policy, Non-occupational Short Term Disability Income Insurance Certificate, Application for Group Insurance, Application - Evidence of Insurability, Voluntary Short Term Disability Employee Enrollment Form

Form Number(s): VSTD11, VSTD11 CER, VSTD11 APP, VSTD11 EI, VSTD11 ENR

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Maureen T. Mullville, CLU, FLMI
Vice President of Compliance and General Counsel

September 15, 2011
Date

Statement of Variable Language for
Group Non-occupational Short Term Disability Insurance and
Accidental Death and Dismemberment Insurance, Form VSTD11 CER (AR)
(September 20, 2011)

Language that is bracketed in the form is intended to be variable. Below is an explanation of those variables.

Page #	Provision/Title	Description of Variable
1	Employee Name	John Doe Information
	Certificate Number	John Doe Information
	Effective Date	John Doe Information
	Employer	John Doe Information
	Definitions of Actively at Work in Class Description: 30 (hours per week)	Employer selection always in accordance with state requirements, if any.
	Age range of full-time active employees included in Class Description	Employer selection always in accordance with state requirements, if any.
	Qualifying Period : days actively at work	Employer selection always in accordance with state requirements, if any.
	Elimination Period: Accident:	These will vary by plan: Plan A: 1st day Plan B: 8th day Plan C: 15th day Plan D: 1st day Plan E: 8th day Plan F: 15th day Plan G: 8th day Plan H: 15th day
	Elimination Period: Sickness:	These will vary by plan: Plan A: 8th day Plan B: 8th day Plan C: 15th day Plan D: 8th day Plan E: 8th day Plan F: 15th day Plan G: 8th day Plan H: 15th day
	Maximum Total Disability Period	These will vary by plan: Plans A, B and C: 13 weeks Plans D, E, and F: 26 weeks Plans G and H: 52 weeks
	Maximum AD&D Benefit	Employer selection always in accordance with state requirements, if any
	Waiver of Premium	Employer selection always in accordance with state requirements, if any
3	Definitions of Actively at Work: [30] hours per week	Employer selection always in accordance with state requirements, if any
4-5	Benefits reduced for pensions, retirement systems and contributory plans	Employer selection always in accordance with state requirements, if any
5	Total Disability minimum	Employer selection always in accordance with state requirements, if any
	Minimum weekly benefit	Employer selection always in accordance with state requirements, if any
	AD&D Benefit – or sickness	Employer selection always in accordance with state requirements, if any
8	Reinstated policy provisions (a)	Employer selection always in accordance with state requirements, if any
	Reinstated policy provisions (b)	Employer selection always in accordance with state requirements, if any

Statement of Variable Language for
Group Non-occupational Short Term Disability Insurance and
Accidental Death and Dismemberment Insurance, Form VSTD11 (AR)
(September 15, 2011)

Language that is bracketed in the form is intended to be variable. Below is an explanation of those variables.

Page #	Provision/Title	Description of Variable
1	Policyholder Name	John Doe Information
	Date of Issue	John Doe Information
	Policy No.	John Doe Information
	Policy Anniversary	12 Months after Date of Issue
	Premium Due Date	Same as Date of Issue
3	Class A – Full-time active employee	Employer selection always in accordance with state requirements, if any
	Class A – Ages	Employer selection always in accordance with state requirements, if any
	Qualifying Period	Employer selection always in accordance with state requirements, if any
	Benefit Schedule	Employer selection of one or more of the plans shown
	AD&D Benefit	Employer selection always in accordance with state requirements, if any
	Waiver of Premium	Employer selection always in accordance with state requirements, if any
	Premium Schedule	Employer selection of one or more of the plans shown
4	Definitions of Actively at Work: 30 (hours per week)	Employer selection always in accordance with state requirements, if any
6	Employees Eligible for Insurance – Continuous employment period	Employer selection always in accordance with state requirements, if any
	Employees Eligible for Insurance – hours per week	Employer selection always in accordance with state requirements, if any
	Employees Eligible for Insurance – qualification for new employees	Employer selection always in accordance with state requirements, if any
7-8	Benefits reduced for pensions, retirement systems and contributory plans	Employer selection always in accordance with state requirements, if any
8	Total Disability minimum	Employer selection always in accordance with state requirements, if any
	Minimum weekly benefit	Employer selection always in accordance with state requirements, if any
11	Reinstated policy provisions (i)	Employer selection always in accordance with state requirements, if any
	Reinstated policy provision (ii)	Employer selection always in accordance with state requirements, if any

September 15, 2011

To: The Insurance Commissioner

Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

Illinois Mutual Life Insurance Company

By: 

Title: Vice President of Compliance and General Counsel

SERFF Tracking Number:	*FRCS-127658169*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*49902*
Company Tracking Number:	*5606*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group VSTD*		
Project Name/Number:	*ILMUTUAL/61/61*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/28/2011	Form	Group Non-occupational Short Term Disability Insurance Policy	10/20/2011	Form VSTD11 (AR).pdf (Superceded)
09/28/2011	Form	Non-occupational Short Term Disability Income Insurance Certificate	10/20/2011	Form VSTD11 CER (AR).pdf (Superceded)

ILLINOIS MUTUAL®

A Mutual Life Insurance Company

Policyholder	[ABC COMPANY]	Date of Issue	[October 1, 2012]
Policy No.	[0001]	Policy Anniversary	[October 1, 2013] and annually thereafter
State of Delivery	Arkansas		
Premium Due Date	[October 1, 2012 and monthly thereafter]		

THE COMPANY AGREES TO PAY the group insurance benefits for each insured Employee of the Policyholder according to the terms of this Policy.

This Policy is issued to the Policyholder in consideration of the application of the Policyholder and the payment of the required premiums. It will take effect on the Date of Issue. This Policy will terminate upon failure to pay any premium before the end of the grace period allowed for payment. It will also terminate after written notice by the Company or by the Policyholder.

Premiums are payable in the amounts determined as stated herein. The first premium is due on the Date of Issue. Renewal Premiums are due as stated above during the continuance of this Policy unless the Policyholder and Illinois Mutual Life Insurance Company agree on some other method of premium payment.

This Policy is delivered in and is governed by the laws of the State of Delivery noted above.

This Policy is signed by our President and Secretary in Peoria, Illinois on the Date of Issue.

Secretary

Chairman & CEO

FOR INFORMATION, OR TO MAKE A COMPLAINT, CALL 800-437-7355
If you need information about your insurance, or should any dispute arise about your premium or about a claim that you have filed, call Illinois Mutual Life Insurance Company at the toll-free number listed above or contact the Arkansas Insurance Department, 1200 West Third Street, Little Rock, AR 72201 or toll-free at 1-800-282-9134.

Group Non-occupational Short Term Disability Insurance
and
Accidental Death and Dismemberment Insurance
Renewable at the Option of the Company

Illinois Mutual Life Insurance Company
Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 800.437.7355

INDEX

BENEFIT SCHEDULE

Class A **Class Description** Full-time active employees working [30] or more hours per week, Ages [18-67]

Qualifying Period [30-90] Days

Plan	Elimination Period Accident	Elimination Period Sickness	Maximum Total Disability Benefit Period	Plan	Elimination Period Accident	Elimination Period Sickness	Maximum Total Disability Benefit Period
[A	0 Days	7 Days	13 Weeks	E	7 Days	7 Days	26 Weeks
B	7 Days	7 Days	13 Weeks	F	14 Days	14 Days	26 Weeks
C	14 Days	14 Days	13 Weeks	G	14 Days	14 Days	52 Weeks
D	0 Days	7 Days	26 Weeks	H	30 Days	30 Days	52 Weeks

Each Employee may select a Level of Benefit listed below. The Employee's selection is included in the Employee's Enrollment Form and in the Employee's Schedule of Benefits included in his Certificate of Coverage.

Benefit Level	Weekly* Benefit	Minimum Annual Salary	Benefit Level	Weekly* Benefit	Minimum Annual Salary
1	$150	$11,700	6	$400	$31,200
2	$200	$15,600	7	$450	$35,000
3	$250	$19,500	8	$500	$39,000
4	$300	$23,400	9	$550	$42,900
5	$350	$27,300	10	$600	$46,800]

*Weekly Benefit cannot exceed 66 2/3% of Employee's Basic Weekly Earnings

Maximum Accidental Death and Dismemberment Benefit [$10,000]

Waiver of Premium [Included]

PREMIUM SCHEDULE

Premium Rates per $100 of Benefit – Employee Pays 100% of Premium

Age	[Plan A Premium	Plan B Premium	Plan C Premium	Plan D Premium
Under 30	$8.14	$7.75	$6.89	$9.56
30-34	$8.38	$8.00	$7.02	$9.91
35-39	$8.38	$8.00	$7.02	$9.91
40-44	$8.38	$8.00	$7.02	$9.91
45-49	$8.85	$8.38	$7.41	$11.45
50-54	$10.62	$10.13	$8.84	$13.69
55-59	$12.39	$11.88	$10.40	$16.17
60-64	$14.51	$13.88	$12.22	$18.88
65-69	$19.12	$18.25	$15.99	$24.90

Age	Plan E Premium	Plan F Premium	Plan G Premium	Plan H Premium
Under 30	$9.25	$8.32	$10.37	$8.19
30-34	$9.75	$8.71	$10.81	$8.50
35-39	$9.75	$8.71	$10.81	$8.50
40-44	$9.75	$8.71	$10.81	$8.50
45-49	$11.13	$10.01	$12.39	$9.74
50-54	$13.25	$11.96	$14.84	$11.74
55-59	$15.63	$14.17	$17.58	$13.75
60-64	$18.38	$16.51	$20.60	$16.23
65-69	$24.25	$21.84	$27.09	$21.32]

DEFINITIONS

For all purposes of this Policy:

Actively at Work means the Employee is performing all of the duties of his job with the Employer at least [30] hours per week.

Basic Weekly Earnings means the Employee's rate of earnings from the Employer in effect immediately prior to the date the Employee's Total Disability begins. It does not include bonuses, overtime pay and other extra compensation other than commissions. Commissions will be averaged over the 12 month period prior to the date of the Employee's Total Disability begins.

Coverage Date means the date which the Employee's coverage under the Policy begins.

Effective Date means the date on which the Policy becomes effective.

Elimination Period means the number of continuous days an Employee must be Totally Disabled before benefits begin to accrue and become payable. No benefits are payable for the Elimination Period. The Elimination Period may be different for disabilities due to Sickness than it is for Injury.

Employee means a person directly employed in the regular business of, and compensated for service by, the Employer. A director of a corporate employer shall not be deemed an Employee solely because of such directorship.

Employer means the entity or person, including any affiliates or subsidiaries named in the application, and who has agreed to provide benefits to its employees as provided in this Policy.

He and Him mean an insured Employee, whether male or female.

Injury means accidental bodily injury independent of disease, sickness or bodily infirmity that the Employee sustains while his coverage is in force and which does not arise out of any employment for wage or profit.

Physician means a doctor or practitioner, other than the Employee or a member of the Employee's immediate family, who is duly licensed by the proper authority and who is practicing within the scope of the Physician's license.

Policy means the group policy issued to the Employer.

Policy Anniversary means 12 months after the Date of Issue of this Policy to the Policyholder and each subsequent 12 month period.

Policyholder means the entity or person named in this Policy.

Pregnancy includes childbirth, miscarriages, and complications of Pregnancy.

Qualifying Period means the number of continuous days as stated in the Schedule of Benefits you are at Actively at Work before your Coverage Date may begin if you apply for coverage under the Policy.

Regular Care of a Physician means treatment, consultations and diagnostic services provided by a Physician whose specialty is suitable for the condition causing your disability. Such care must be received in-person at a frequency that is appropriate for the Employee's Injury or Sickness according to accepted medical standards. We may waive this regular care requirement upon receipt of reasonable proof that such care is no longer appropriate for the Injury or Sickness causing the Employee's disability.

Sickness means an illness, disease, or physical condition of the Employee which first manifests itself while his coverage is in force and which does not arise out of any employment for wage or profit. Pregnancy is covered as any other sickness for the purpose of providing benefits under this Policy, subject to all Policy provisions.

DEFINITIONS (cont.)

Total Disability for any one period of disability, starting while the Employee's coverage is in force, means, as a result of Sickness or Injury, the Employee's inability to engage in any occupation for which he is qualified or for which he becomes qualified by education, training, or experience.

To be Totally Disabled, the Employee must be under the regular care of a physician. Only one total disability benefit will be payable at any one time even if the Employee is Totally Disabled because of multiple causes.

We, Us and Our mean Illinois Mutual Life Insurance Company or the Company.

PREMIUM PROVISIONS

Computation of Premiums: The premium rates shown in the Schedule shall be used in computing the amounts of premiums due Policyholder under the Policy. However, the Company may, on any of the following dates, establish a new rate upon which further premiums shall be computed:

1. any premium due date, provided the rate schedule that is then in effect has been in effect at least 12 months, and the Company notifies the Policyholder at least 31 days in advance of such premium due date; or
2. whenever the terms of this Policy are changed.

As of the Effective Date of this Policy, the Company will determine the premiums due for each enrolled Employee based on his age last birthday and the amount of insurance coverage selected.

Thereafter, on each Policy Anniversary:

1. a premium adjustment will be made for any Employee whose attained age places him in a higher premium bracket; and/or
2. a premium adjustment will be made for any Employee who requests a change in his Benefit Level because of a salary increase/decrease that has occurred for that employee. The Employee must furnish evidence of insurability if his Benefit Level is to be increased. Such changes must be approved by the Company.

Premium adjustments that involve a return of unearned premium, will be returned to the Employee upon receipt by the Company of evidence that such adjustment should be made.

Payment of Premiums: All premiums due under this Policy, and any adjustments, are to be paid on or before their due date. Premiums are to be paid at the Home Office of the Company. The payment of any premiums shall keep this insurance in force only through the date just before the next due date, unless otherwise stated herein.

Grace Period – Termination of Policy: A grace period of 31 days will be allowed for payment of any premium due after the first. No interest will be due for the grace period. During the grace period this Policy shall stay in force. However, this Policy shall not stay in force during the grace period if the Policyholder has, prior to the premium due date, given written notice to the Company that this coverage is to be terminated on the day immediately preceding such premium due date.

If the Policyholder fails to pay any premium within the grace period, coverage for its Employees shall automatically terminate on the last day of such grace period. The Policyholder shall, nevertheless, be liable to the Company for the payment of all premiums then due and unpaid. This shall include a pro rata premium for the grace period.

Written notice may be given by the Policyholder to the Company during the grace period that its coverage is to be terminated before the expiration of the grace period. If so, coverage shall be terminated as of the later of:

1. the date of receipt of such written notice by the Company, or
2. the date specified by the Policyholder for such termination.

PREMIUM PROVISIONS (cont.)

The Policyholder shall be liable to the Company for the payment of all premiums then due and unpaid. This shall include a pro rata premium for the period starting with the last premium due date and ending with such date of termination.

The Company may terminate this Policy on the first policy anniversary or on any premium due date thereafter. It may do so if it gives written notice to the Policyholder at least 31 days in advance.

ADMINISTRATION PROVISIONS

Record of Employees Insured
The Company shall maintain a record which shall show at all times the following:

1. the names of all Employees insured hereunder;
2. the date when each Employee became insured;
3. the amount for which he is insured;
4. the effective date of any increase or decrease in the amount of his insurance;
5. information necessary to determine the age of each Employee; and
6. such other information as may be required to administer the insurance hereunder.

The Policyholder shall furnish from time to time to the Company such information about Employees becoming insured and terminations of employees as the Company may require. The Company will be allowed to examine the records of the Policyholder relating to this Policy. This may be done at any reasonable time up to 2 years after the cancellation of this Policy, or until settlement of all claims, whichever is later.

Inadvertent error, failure or omission on the part of the Policyholder to report the name of any Employee who has qualified for the insurance hereunder in accordance with the prescribed conditions, or whose amount of insurance is to be changed in accordance with the provisions hereof, shall not deprive such Employee of insurance nor affect the amount thereof. Failure to report the termination of insurance on any Employee shall not be construed as involving or effecting the continuation of such insurance beyond the date of termination determined in accordance with the provisions hereof.

Employee's Certificate
The Company will issue a Certificate of Insurance for each insured Employee. The Certificate will be delivered to the Employee and shall state the insurance protection. It shall state such limitations or requirements in this Policy as may pertain to the insured Employee.

INSURANCE PROVISIONS

Employees Eligible for Insurance
Subject to the provisions of this Policy, each Employee is eligible for insurance from the Effective Date if he:

1. has completed a continuous employment period of [0-90] days;
2. is a full-time Employee working [30-40] hours per week or more; and
3. is between the ages of 18 through 65.

Each person who becomes a full-time Employee after the Effective Date is eligible for insurance on the first day after he completes a continuous employment period of [0-90] days.

Effective Dates of Insurance
Each Employee who makes a written request for insurance on a Company form shall, subject to the provisions of this Policy, become insured as follows:

1. If he makes the request on or before the date he becomes eligible, he shall become insured on the date he becomes eligible.
2. If he makes the request within 31 days after the first day he is both eligible and Actively at Work, he shall become insured on the date of the request.

3. If he makes the request more than 31 days after the first day on which he is both eligible and Actively at Work, he shall become insured on the date the Company agrees to his insurability.

If an Employee is not Actively at Work as a full-time employee on the date he would otherwise become insured, he will not become insured until the next day on which he is Actively at Work as a full-time employee.

Individual Termination of Insurance
The insurance on an Employee shall terminate upon the earliest of the following dates:

1. the date his employment is terminated with the Employer. An Employee's employment is deemed terminated if he is no longer Actively at Work except for periods during which he is eligible for Total Disability Weekly Benefit;
2. the date the Policy is terminated or amended to end coverage for class to which an Employee belongs;
3. the date of termination of the Policy; or
4. the date of the expiration of the last period for which he has made a contribution, in the event of his failure to make, when due, any contribution toward the payment of premium for insurance to which he has agreed in writing.

Termination of the Policy will not affect any claim that the Employee may have for a loss that begins prior to the termination of the Policy.

NON-OCCUPATIONAL DISABILITY INCOME BENEFITS

Total Disability Weekly Benefit
If injury or sickness causes the Employee's Total Disability, we shall pay him the Total Disability Weekly Benefit shown in the Schedule which he has elected. However, in no event shall this Benefit be more than 66 2/3% of the Employee's Basic Weekly Earnings. This Benefit shall be paid to him after the Elimination Period shown in the Schedule has been satisfied. This Benefit shall be paid to him for as long as he is Totally Disabled up to the Maximum Total Disability Benefit Period shown in the Schedule for any one period of total disability.

If termination of insurance coverage occurs during a period of total disability, benefits will continue to be paid until the earliest of:

1. the date his Total Disability ends; or
2. the Maximum Total Disability Benefit Period has been reached.

However, any Total Disability Weekly Benefit payable under the Policy will be reduced by the amount of any other income benefits which the Employee receives or is eligible to receive. Other income benefits are:

1. [retirement pension benefits to the extent paid for by the Employee under
   a. any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with the Employer; or
   b. any plan which the Employer sponsors, or makes or has made contributions] [and]
2. disability benefits under any plan of a federal, state, county or municipal retirement system, if such benefits include any credit for employment with the Employer; and
3. disability benefits under the United States Social Security Act, the Railroad Retirement Act or under any similar United States or Canadian plan or act; and
4. unemployment compensation under any state or federal law; and
5. disability benefits under any individual or group disability policy paid for by the Policyholder and purchased on or after the Effective Date of the Policy; and
6. amounts received under any salary continuation, paid time off or accumulated sick leave plan sponsored by the Policyholder. This includes donated or lump sum sick leave benefits or paid time off.]

NON-OCCUPATIONAL DISABILITY INCOME BENEFITS (cont.)

[The Total Disability Weekly Benefit will never be less than [$50].]

For any period of Total Disability for which a Benefit is payable that is less than a full week, the benefit will be prorated. Proration will be determined by dividing the amount of the Employee's Total Disability Weekly Benefit by 7 and multiplying this amount by the number of days he is Totally Disabled.

Recurrent Disability
A recurrence of the Employee's disability from the same or related causes will be considered a continuation of the prior period unless he has been engaged in any gainful occupation for more than 14 continuous days. The Employee must be reasonably fitted and have been performing all of the substantial and material duties of that occupation.

If the Employee's disability is treated as a recurrent Total Disability of the prior period, it will not be subject to a new Elimination Period or a new Maximum Total Disability Benefit Period.

PRE-EXISTING CONDITION LIMITATION

During the first 12 months after the Effective Date of the Employee's coverage, we will not pay benefits:
(a) for any condition diagnosed or treated by a physician within 12 months prior to the Effective Date; or
(b) for any condition which caused symptoms within 12 months prior to the Effective Date that would have caused an ordinarily prudent person to seek medical diagnosis, care or treatment.

In the event the Employee applies for an increased Benefit Level, we will not pay benefits on the increased portion of the Benefit Level during the first 12 months prior to the Effective Date of the Employee's increased Benefit Level for any condition diagnosed or treated by a physician within that period or for any condition which caused symptoms within 12 months prior to the Effective Date of the Employee's increased Benefit Level that would have caused an ordinarily prudent person to seek medical diagnosis, care or treatment.

EXCEPTIONS AND LIMITATIONS

The Employee's coverage does not insure against or pay benefits for any disability which is caused by or is the result of:
(a) intentionally self-inflicted injuries or attempted suicide, while sane or insane; or
(b) his commission of a felony; or
(c) war, declared or undeclared; or
(d) Injury or Sickness arising out of or in the course of any employment for wage or profit.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

An Accidental Death and Dismemberment Benefit will be payable up to the Accidental Death and Dismemberment Benefit stated on the Schedule, provided such loss:
1. Results from Injury, independent of disease and Sickness; and
2. Is caused by an accident that occurs while this Benefit is in force; and
3. Occurs within 90 days of that accident.

A percentage of this Benefit will be paid to the Employee as follows:

Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and the Entire Sight of One Eye	100%
Loss of One Foot and the Entire Sight of One Eye	100%
Loss of One Hand or One Foot	50%
Loss of Entire Sight of One Eye	50%

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (cont.)

For this Benefit to be payable, Loss means:

1. with reference to hand or foot, complete loss of the use of the hand, or foot; and
2. with reference to eye, irrecoverable loss of the entire sight of the eye.

If the Employee suffers more than one of the above losses as a result of the same accident, the Benefit provided will be paid only for the greatest loss.

This Benefit will be paid to the Employee, if living; otherwise to the named Beneficiary. If no Beneficiary is named, the Benefit will be paid to the Estate of the Employee.

The Accidental Death and Dismemberment Benefit will provide no Benefit for any loss caused by or resulting from:

1. Declared or undeclared war or any act of war;
2. Service in the armed forces of any country or international authority;
3. Suicide or intentionally self-inflicted injury whether the Employee was sane or insane at the time of the suicide or injury.
4. Flying in an aircraft owned, operated, leased or chartered by the Policyholder;
5. Participation in, or in consequence of having participated in, the commission of any felony;
6. Sickness or disease, or infection, except infections which result from an accidental injury or infections which result from accidental, involuntary or an unintentional ingestion of a contaminated substance.
7. Intentionally taking a narcotic, drug, barbiturate, hallucinogenic drug or any combination of these when not part of a professional medical treatment plan.
8. Intoxication by the intentional use of alcohol. Intoxication means that which is defined and determined by the laws of the state where the loss or cause of the loss was incurred.

BENEFICIARY PROVISION

The beneficiary shall be as shown in the Employee's enrollment form for this coverage. The Employee may change a beneficiary at any time by sending a written request to us unless an irrevocable beneficiary has been named.

A change of beneficiary will not take effect until it is recorded by us. When the change is so recorded, it will take effect as of the date that the written request was signed, whether or not the Employee is living when the change is recorded. We will not be liable for any proceeds paid prior to such recording.

WAIVER OF PREMIUM PROVISION

The premium for insurance for the Employee will be waived in certain situations. He must become entitled to receive Total Disability Weekly Benefits under the Policy. His total disability must have existed for at least 90 days in a row. If these two conditions are met, we will waive each monthly premium due for his insurance after his first 90 days of Total Disability. When he is no longer Totally Disabled, premiums must be paid as they become due.

GENERAL PROVISIONS

1. Entire Contract: This Policy and the application of the Policyholder, a copy of which is attached hereto, constitute the entire contract between the parties.

All statements made by the insured Employee shall be deemed representations and not warranties and no statement made by an insured Employee shall avoid the insurance or be used in defense to a claim hereunder unless a copy of the instrument containing such statement is or has been furnished to such Employee.

2. Amendment and Alteration of the Contract: This Policy may be amended or changed at any time, subject to the laws of the jurisdiction in which it is delivered, without the consent of the Employees insured hereunder by written agreement between the Policyholder and the Company.

Only the President, a Vice President, the Secretary or an Assistant Secretary of the Company has power to change, modify or waive the provisions of this Policy, and then only in writing. The Company shall not be bound by any promise or representation heretofore or hereafter made by or to any agent or person other than as above.

3. Notice of Claim: Written notice of a claim must be given to us within 20 days after a loss starts or as soon as reasonably possible. Such notice may be given to Our Home Office or to any of our authorized agents. Such notice should include the Employee's name.

4. Claim Forms: Upon receipt of notice of claim, we will send the forms for filing proof of loss. If these forms are not furnished within 15 days, the Employee will have met the proof of loss requirements by giving Us a written statement of the nature and extent of the claim within the time stated below for Proofs of Loss.

5. Proofs of Loss: Written proof of loss for a periodic payment due for a continuing loss must be given to us within 90 days after the end of each period for which We are liable. For any other loss, written proof of loss must be given within 90 days after such loss.

If it was not reasonably possible for the Employee to give such proof within the time required, we shall not reduce the claim for such reason if the proof is filed as soon as reasonably possible. Such proof must be given no later than one year from the time specified above unless lack of legal capacity prevents it.

6. Time of Payment of Claim: After receiving written proof of loss, we will pay at the end of each 7 days all benefits for the Employee's continuing disability for which we are liable. Any balance unpaid at the end of the disability will be paid as soon as we receive written proof. Benefits for any other loss covered by the Policy will be paid as soon as we receive proper written proof.

7. Payment of Claim: Subject to due proof of loss, benefits will be paid each week during any period for which we are liable. Any balance unpaid at the termination of such period will be paid upon receipt of due proof.

All benefits will be paid to the Employee. However, in the following cases we may pay up to $1,000 to any relative by blood or connection by marriage of the Employee who is deemed by Us to be fairly entitled thereto:

(a) when the benefit is payable to his estate;
(b) when the benefit is payable to a minor;
(c) when the benefit is payable to anyone else that is not legally competent.

Any payment made by us in good faith under this provision shall fully discharge Us to the extent of such payment.

8. Physical Examination and Autopsy: We shall have the right at our expense to have the Employee examined as often as is reasonably necessary while a claim is pending. Benefits shall cease if the Employee does not submit to an examination when reasonably requested by us. At our own expense, we may have an autopsy made unless prohibited by law.

9. Legal Actions: No legal action may be taken to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No legal action may be taken after 3 years from the time written proof of loss is required to be given.

GENERAL PROVISIONS

10. Misstatement of Age: If the Employee's age has been misstated, we shall adjust the premium. If his amount of insurance would be affected by such misstatement of age, it shall be adjusted to that to which he would have been entitled at his correct age. The adjustment in premium shall be based on such adjusted amount of insurance.

11. No Assignment: The Employee's Certificate of Insurance cannot be assigned. The benefits cannot be assigned prior to a loss.

12. Incontestability: We may contest the validity of the Employee's insurance only if:

(a) we contest a statement made by him relating to his insurability within 2 years of the date his insurance initially became effective or within 2 years of the effective date of an increase in the benefit amount; and

(b) the statement is in writing and signed by him.

13. Reinstatement: If any renewal premium is not paid within the grace period, this Policy will lapse. Later acceptance of the premium by us or by our agent authorized to accept premiums, without requiring an application for reinstatement, will reinstate this Policy.

If we or our agent require an application, the Policyholder will be given a conditional receipt for the premium. If the application is later approved by us, this Policy will be reinstated as of the date of our approval. If not approved by us, this Policy will be reinstated on the 45th day after the date of the conditional receipt unless we have already given the Policyholder written notice of its disapproval.

After reinstatement, this Policy will cover only [(i)] a total disability that results from an injury sustained after the date of reinstatement or a sickness that begins more than 10 days after such date. [or (ii) a loss that results from an accident so long as the accident occurs after the date of reinstatement.]

In all other respects the Employee's rights and our rights will stay the same, subject to any provisions that are endorsed on or attached to this Policy at the time of reinstatement.

14. Conformity With State Statutes: Any provision of the Policy which, on its effective date, is in conflict with a law of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of said law.

Group Non-occupational Short Term Disability Insurance
and
Accidental Death and Dismemberment Insurance
Renewable at the Option of the Company

Illinois Mutual Life Insurance Company
Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 800.437.7355

FOR INFORMATION, OR TO MAKE A COMPLAINT, CALL 800-437-7355
If you need information about your insurance, or should any dispute arise about your premium or about a claim that you have filed, call Illinois Mutual Life Insurance Company at the toll-free number listed above or contact the Arkansas Insurance Department, 1200 West Third Street, Little Rock, AR 72201 or toll-free at 1-800-282-9134.

ILLINOIS MUTUAL®

A Mutual Life Insurance Company

GROUP INSURANCE PLAN

CERTIFICATE OF INSURANCE

Non-occupational Short Term Disability Income Insurance
and
Accidental Death and Dismemberment Insurance

This Certificate is issued to all employees of the Employers who become eligible for benefits, subject to the provisions of Policy, as described in this certificate.

Employee [John Doe] **Certificate No.** [0001]

Effective Date [October 1, 2012]

Employer [ABC Company]

BENEFIT SCHEDULE

Class A **Class Description** Full-time active employees working [30] or more hours per week, Ages [18-67]

Qualifying Period [30-90] days
Elimination Period
Accident [8] Days
Sickness [8] Days

Maximum Total Disability Benefit Period

Total Disability Weekly Benefit

*Weekly Benefit cannot exceed 66 2/3% of Your Basic Weekly Earnings

Maximum Accidental Death and Dismemberment Benefit [$10,000]

Waiver of Premium [Included]

This Certificate of Insurance is intended to present the Group Plan in non-technical language. As a Certificate of Insurance, it explains but it is not the contract of insurance which has been issued to and is in the possession of the Employer at its Home Office.

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DEFINITIONS

Actively at Work means you are performing all of the duties of your job with the Participating Employer at least [30] hours per week.

Basic Weekly Earnings means your rate of earnings from the Employer in effect immediately prior to the date your Total Disability begins. It does not include bonuses, overtime pay and other extra compensation other than commissions. Commissions will be averaged over the 12 month period prior to the date your Total Disability begins.

Coverage Date means the date which your coverage under the Policy begins.

Effective Date means the date on which the Policy becomes effective.

Elimination Period means the number of continuous days you must be Totally Disabled before benefits begin to accrue and become payable. No benefits are payable for the Elimination Period. The Elimination Period may be different for disabilities due to Sickness than it is for Injury.

Employee means a person directly employed in the regular business of, and compensated for service by, the Employer. A director of a corporate employer shall not be deemed an Employee solely because of such directorship.

Employer means the employer who has agreed to provide group insurance benefits to its employees.

Injury means accidental bodily injury independent of disease, sickness or bodily infirmity that you sustain while your coverage is in force and which does not arise out of any employment for wage or profit.

Physician means a doctor or practitioner, other than you or a member of your immediate family, who is duly licensed by the proper authority and who is practicing within the scope of his license.

Policy means the group policy issued to the Employer which provides the coverage described in this Certificate.

Pregnancy includes childbirth, miscarriages, and complications of Pregnancy.

Qualifying Period means the number of continuous days as stated in the Schedule of Benefits you are at Actively at Work before your Coverage Date may begin if you apply for coverage under the Policy.

Regular Care of a Physician means treatment, consultations and diagnostic services provided by a Physician whose specialty is suitable for the condition causing your disability. Such care must be received in-person at a frequency that is appropriate for your Injury or Sickness according to accepted medical standards. We may waive this regular care requirement upon receipt of reasonable proof that such care is no longer appropriate for the Injury or Sickness causing your disability.

Sickness means an illness, disease, or physical condition of you which first manifests itself while your coverage is in force and which does not arise out of any employment for wage or profit. Pregnancy is covered as any other sickness for the purpose of providing benefits under this Policy, subject to all Policy provisions.

Total Disability for any one period of disability, starting while your coverage is in force, means, as a result of Injury or Sickness, your inability to engage in any occupation for which you are or for which you become qualified by education, training, or experience. To be Totally Disabled, you must be under the Regular Care of a Physician. Only one Total Disability benefit will be payable at any one time even if you are Totally Disabled because of multiple causes.

We, Us and Our mean Illinois Mutual Life Insurance Company or the Company.

You and Your refers to the insured Employee named in the Schedule.

YOUR ELIGIBILITY FOR GROUP COVERAGE

You become eligible:

(a) on the Effective Date of the Policy, if you are within the eligible classes insured; or

(b) on the day immediately following completion of the required Qualifying Period, if you are within the eligible classes after the Effective Date of the Policy.

YOUR GROUP COVERAGE BEGINS

Your coverage begins:

(a) on the date you become eligible, if you have made application on or before said date.

(b) on the date you make application, if you have made application within 31 days after you became eligible.

(c) on the date we approve your evidence of insurability, if you make application more than 31 days after the date you first became eligible.

Your coverage does not begin unless you are Actively at Work. If you are not Actively at Work, your coverage begins on the first day you are Actively at Work.

YOUR COVERAGE TERMINATES

Your coverage terminates immediately upon the earliest of the following dates:

(a) the date your employment is terminated with the Employer. Your employment is deemed terminated if you are no longer Actively At Work except for periods during which you are eligible for Total Disability Weekly Benefit;

(b) the date the Employer terminates coverage under the Policy;

(c) when you fail to make a premium payment when due or;

(d) when you cease to be within a class eligible for insurance.

Termination of the Policy will not affect any claim you may have for a loss that begins prior to the termination of the Policy.

NON-OCCUPATIONAL DISABILITY INCOME BENEFITS

Total Disability Weekly Benefit

If Injury or Sickness causes your Total Disability, we shall pay you the Total Disability Weekly Benefit shown in the Schedule which you elected. However, in no event shall this Benefit be more than 66 2/3% of your Basic Weekly Earnings. This Benefit shall be paid to you after the Elimination Period shown in the Schedule has been satisfied. This Benefit shall be paid to you for as long as you are Totally Disabled up to the Maximum Total Disability Benefit Period shown in the Schedule for any one period of Total Disability.

If termination of insurance coverage occurs during a period of Total Disability, benefits will continue to be paid until the earliest of:

1. the date your Total Disability ends; or
2. the Maximum Total Disability Benefit Period has been reached.

However, any Total Disability Weekly Benefit payable to you under the Policy will be reduced by the amount of any other income benefits which you receive or are eligible to receive. Other income benefits are:

1. [retirement pension benefits to the extent paid for by the Employee under
   a. any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with the Employer; or
   b. any plan which the Employer sponsors, or makes or has made contributions][and.
2. disability benefits under any plan of a federal, state, county or municipal retirement system, if such benefits include any credit for employment with the Employer; and
3. disability benefits under the United States Social Security Act, the Railroad Retirement Act or under any similar United States or Canadian plan or act; and

NON-OCCUPATIONAL DISABILITY INCOME BENEFITS (cont.)

4. unemployment compensation under any state or federal law; and
5. disability benefits under any individual or group disability policy paid for by the Policyholder and purchased on or after the Effective Date of the Policy; and
6. amounts received under any salary continuation, paid time off or accumulated sick leave plan sponsored by the Policyholder. This includes donated or lump sum sick leave benefits or paid time off.]

[The Total Disability Weekly Benefit will never be less than [$50].]

For any period of Total Disability for which a Benefit is payable that is less than a full week, the benefit will be prorated. Proration will be determined by dividing the amount of your Total Disability Weekly Benefit by 7 and multiplying this amount by the number of days you are Totally Disabled.

Recurrent Disability
A recurrence of your Total Disability from the same or related causes will be considered a continuation of the prior period unless you have been engaged in any gainful occupation for more than 14 continuous days. You must be reasonably fitted and have been performing all of the substantial and material duties of that occupation.

If your Total Disability is treated as a recurrent Total Disability of the prior period, it will not be subject to a new Elimination Period or a new Maximum Total Disability Benefit Period.

PRE-EXISTING CONDITION LIMITATION

During the first 12 months after the Effective Date of your coverage, we will not pay benefits:

(a) for any condition diagnosed or treated by a physician within 12 months prior to the Effective Date; or
(b) for any condition which caused symptoms within 12 months prior to the Effective Date that would have caused an ordinarily prudent person to seek medical diagnosis, care or treatment.

In the event you apply for an increased Benefit Level, we will not pay benefits on the increased portion of the Benefit Level during the first 12 months prior to the Effective Date of your increased Benefit Level for any condition diagnosed or treated by a physician within that period or for any condition which caused symptoms within 12 months prior to the Effective Date of your increased Benefit Level that would have caused an ordinarily prudent person to seek medical diagnosis, care or treatment.

EXCEPTIONS AND LIMITATIONS

1. Your coverage does not insure against or pay benefits for any disability which is caused by or is the result of:
   (a) committing or trying to commit suicide or injuring yourself intentionally, whether you are sane or not; or
   (b) participating or attempting to participate in an illegal activity and/or being incarcerated in a penal institution; or
   (c) war or act of war, whether declared or undeclared; or
   (d) injury or sickness arising out of or in the course of any employment for wage or profit.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

An Accidental Death and Dismemberment Benefit will be payable up to the Accidental Death and Dismemberment Benefit stated on the Schedule, provided such loss:

1. results from Injury, independently of disease [or Sickness]; and
2. is caused by an accident that occurs while this Benefit is in force; and
3. occurs within 90 days of that accident.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (cont.)

A percentage of this Benefit will be paid to the Employee as follows:

Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and the Entire Sight of One Eye	100%
Loss of One Foot and the Entire Sight of One Eye	100%
Loss of One Hand or One Foot	50%
Loss of Entire Sight of One Eye	50%

For this Benefit to be payable, Loss means:

1. with reference to hand or foot, complete loss of the use of the hand, or foot; and
2. with reference to eye, irrecoverable loss of the entire sight of the eye.

If you suffer more than one of the above losses as a result of the same accident, the Benefit provided will be paid only for the greatest loss.

This Benefit will be paid to you, if living; otherwise to the named Beneficiary. If no Beneficiary is named, the Benefit will be paid to your estate.

The Accidental Death and Dismemberment Benefit will provide no Benefit for any loss caused by, or resulting from:

1. Declared or undeclared war or any act of war;
2. Service in the armed forces of any country or international authority;
3. Suicide or intentionally self-inflicted injury whether the Employee was sane or insane at the time of the suicide or injury.
4. Flying in an aircraft owned, operated, leased or chartered by the Employer;
5. Participation in, or in consequence of having participated in, the commission of any felony;
6. Sickness or disease, or infection, except infections which result from an accidental injury or infections which result from accidental, involuntary or an unintentional ingestion of a contaminated substance.
7. Intentionally taking a narcotic, drug, barbiturate, hallucinogenic drug or any combination of these when not part of a professional medical treatment plan.
8. Intoxication by the intentional use of alcohol. Intoxication means that which is defined and determined by the laws of the state where the loss or cause of the loss was incurred.

BENEFICIARY PROVISION

The beneficiary shall be as shown in your enrollment form for this coverage. You may change a beneficiary at any time by sending a written request to us unless an irrevocable beneficiary has been named.

A change of beneficiary will not take effect until it is recorded by us. When the change is so recorded, it will take effect as of the date that the written request was signed, whether or not you are living when the change is recorded. We will not be liable for any proceeds paid prior to such recording.

WAIVER OF PREMIUM PROVISION

The premium for insurance for you will be waived in certain situations. You must become entitled to receive Total Disability Weekly Benefits under the Policy. Your Total Disability must have existed for at least 90 days in a row. If these two conditions are met, we will waive each monthly premium due for your insurance after your first 90 days of Total Disability. When you are no longer Totally Disabled, premiums must be paid as they become due

GENERAL PROVISIONS

1. Notice of Claim: Written notice of a claim must be given to us within 20 days after a loss starts or as soon as reasonably possible. Such notice may be given to our Home Office or to any of our authorized agents. Such notice should include your name.

2. Claim Forms: Upon receipt of notice of claim, we will send the forms for filing proof of loss. If these forms are not furnished within 15 days, you will have met the proof of loss requirements by giving us a written statement of the nature and extent of the claim within the time stated below for Proofs of Loss.

3. Proofs of Loss: Written proof of loss for a periodic payment due for a continuing loss must be given to us within 90 days after the end of each period for which we are liable. For any other loss, written proof of loss must be given within 90 days after such loss.

If it was not reasonably possible for you to give such proof within the time required, we shall not reduce the claim for such reason if the proof is filed as soon as reasonably possible. Such proof must be given no later than one year from the time specified above unless lack of legal capacity prevents it.

4. Time of Payment of Claim: After receiving written proof of loss, we will pay at the end of each 7 days all benefits for your continuing disability for which we are liable. Any balance unpaid at the end of the disability will be paid as soon as we receive written proof. Benefits for any other loss covered by the Policy will be paid as soon as we receive proper written proof.

5. Payment of Claim: Subject to due proof of loss, benefits will be paid each week during any period for which we are liable. Any balance unpaid at the termination of such period will be paid upon receipt of due proof.

All benefits will be paid to you. However, in the following cases we may pay up to $1,000 to any relative by blood or connection by marriage of yours who is deemed by us to be fairly entitled thereto:

(a) when the benefit is payable to your estate;
(b) when the benefit is payable to a minor;
(c) when the benefit is payable to anyone else that is not legally competent.

Any payment made by us in good faith under this provision shall fully discharge us to the extent of such payment.

6. Physical Examination and Autopsy: We shall have the right at our expense to have you examined as often as is reasonably necessary while a claim is pending. Benefits shall cease if you do not submit to an examination when reasonably requested by us. At our own expense, we may have an autopsy made unless prohibited by law.

7. Legal Actions: No legal action may be taken to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No legal action may be taken after 3 years from the time written proof of loss is required to be given.

8. Misstatement of Age: If your age has been misstated, we shall adjust the premium. If your amount of insurance would be affected by such misstatement of age, it shall be adjusted to that to which you would have been entitled at your correct age. The adjustment in premium shall be based on such adjusted amount of insurance.

9. No Assignment: Your Certificate of Insurance cannot be assigned. The benefits cannot be assigned prior to a loss.

10. Incontestability: We may contest the validity of your insurance only if:

(a) we contest a statement made by you relating to your insurability within 2 years of the date your insurance initially became effective or within 2 years of the effective date of an increase in the benefit amount; and
(b) the statement is in writing and signed by you.

11. Reinstatement: If any renewal premium is not paid within the grace period, this Policy will lapse. Later acceptance of the premium by us or by our agent authorized to accept premiums, without requiring an application for reinstatement, will reinstate this Policy.

If we or our agent require an application, the Policyholder will be given a conditional receipt for the premium. If the application is later approved by us, this Policy will be reinstated as of the date of our approval. If not approved by

us, this Policy will be reinstated on the 45th day after the date of the conditional receipt unless we have already given the Policyholder written notice of its disapproval.

After reinstatement, this Policy will cover only

[(a)] a Total Disability that results from an Injury sustained after the date of reinstatement or a Sickness that begins more than 10 days after such date[; or

(b) a loss that results from an accident so long as the accident occurs after the date of reinstatement.]

In all other respects your rights and our rights will stay the same, subject to any provisions that are endorsed on or attached to this Policy at the time of reinstatement.

12. Conformity With State Statutes: Any provision of the Policy which, on its effective date, is in conflict with a law of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of said law.

Non-occupational Short Term Disability Income Insurance
and
Accidental Death and Dismemberment Insurance
Renewable at the Option of the Company

Illinois Mutual Life Insurance Company
Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 800.437.7355